Approved

MEETING MINUTES
STATE CONSUMER AND FAMILY ADVISORY COMMITTEE

March 11, 2010

Present: Wilda Brown, Terry Burgess, Gladys Christian, Zack Commander, Bill Cook, Kathy Crocker, Frank Edwards, Laura Keeney, Ron Kendrick, Paul Russ, Andrea Stevens, David Taylor Jr, Rosemary Weaver and Glenda Woodson.
Absent: Nancy Black, Pamela Chevalier, Libby Jones, Carl Noyes, Renee Sisk, and Amelia Thorpe.
Resigned: Marianne Clayter
Staff Present: Mike Watson, Leza Wainwright, Stuart Berde, Cathy Kocian, Kerry Lynn Fraser, Eric Fox, Wes Rider, Ken Marsh, and Kelly Crosbie.
Guests Present: Carolyn Anthony, Martha Brock, Fred Johnson, Ellen Perry, Leigh Stringfellow, Judy Taylor, and Brianna Woodson.

Presenter & Topic	Discussion	Action
Welcome: **Ron Kendrick, SCFAC Chair**	• The meeting was called to order at 9:30 AM. • Ron Kendrick introduced Kerry Lynn Fraser, Advocacy and Customer Service Staff, who has been assisting the SCFAC with administrative support.	The agenda was approved. The January 2010 minutes were approved.
SCFAC Bylaw Revisions	• SCFAC members approved the bylaw changes as written.	
SCFAC 2010 Nominating Committee	• Wilda Brown, Terry Burgess and Zack Commander provided feedback on nominations received for the upcoming positions for SCFAC Chair and Vice Chair. Elections will be held at the May 2010 meeting.	Rosemary Weaver was nominated for SCFAC Chair and Libby Jones for the Vice Chair position.
Public Comment/Issues	• Martha Brock, NC Mental Hope Board Member, distributed a handout from Our Common Voice Collaborative titled *INCLUSION: Suggestions to Improve Consumer Involvement in Decision-making Recommendations to the Legislative Oversight Committee on MH/DD/SA* that was presented to the LOC at the March 10, 2010 meeting. Ron Kendrick, SCFAC Chair, selected Laura Keeney to attend the newly developed collaborative which holds their meetings in Raleigh. In addition, Ms. Brock discussed a PowerPoint presentation *Review of SCFAC Statute passed in 2006* and offered some suggestions. • Zach Commander announced that he was chosen to participate in the first-ever Special Olympics World Congress in Marrakesh, Morocco June 5-10, 2010. The purpose of the event is to provide recommendations for the Special Olympics strategic plan that is under development for the 2011-2015 time period. • David Taylor, Jr. and Ellen Perry shared their good news with SCFAC members regarding their upcoming trip to Hawaii April 10-17, 2010, as international speakers on disability issues.	Martha will send Cathy Kocian the PowerPoint for distribution to SCFAC members.

Mike Watson, DHHS Assistant Secretary	• Mike Watson, DHHS Assistant Secretary, began his career with the Department of Health and Human Services six months ago bringing with him twenty-five years of experience as the former CEO for Sandhills LME. Mike shared some of his own personal experience which includes a family member with developmental disabilities, so he understands the challenges of family members and consumers. Mike talked with SCFAC members about consumer and family involvement and explained there is a need for greater inclusion which he and Leza are open to ways to expand reasonable discussions. • The DHHS and General Assembly (GA) are dealing with extraordinary budget cuts and there is no guarantee that the budget will improve next year. Presently, the DHHS is $250 million behind in budget cuts that were supposed to have already been made with state dollars. The cuts have forced the state and counties to make lots of changes in service provisions. • Currently, the DHHS and Division of MH/DD/SAS are looking at two main priorities: 1. Quality 2. Accountability. There needs to be an absolute focus on quality of care and did people do what they said they would do. Questions to consider include a) were services medically necessary, and b) did Value Options information match what information was in the consumers' record. Community inpatient care is also a priority for concern and this will require expanding psychiatric care at the community level so people who need short term acute care can receive it locally. Last year, the state funded 114 new beds which are located in community hospitals. Presently, there are serious problems in the local emergency rooms and the state is concerned with the wait times because beds in private and state hospitals are not available. • The next main initiative involves the CABHAs, and the GA gave instructions to re-introduce case management into the system while community support services are being phased out and also bring in peer support services. The goal is to improve quality of service and connect the services offered with clinically sound practice. The requirements to be a CABHA include: o A full-time Medical Director, o A full-time Clinical Director, o National accreditation for at least 3 years, and o A full-time Quality Management/Training Director. The Division has allowed exceptions for medical professionals with qualified experience. Only the CABHAs will be allowed to provide Community Support Treatment (CST), Day Treatment and Intensive In-home. The two area of concern include the time frame with which the CABHAs need to be in place and the availability of medical directors. Presently, the Division has	

	received over 400 letters of Intent and over 60 providers have submitted attestation letters to become a CABHA. • Frank Edwards inquired about the proposed service definitions and is concerned that the same abuse seen with community support services (CSS) might be seen with case management. In addition, Frank mentioned that there are some very good small providers who will be eliminated due to CABHAs. Mike Watson acknowledged that there will be less providers and he is concerned there will be less services due to rate cuts. He also explained that the Division is trying to get CMS to approve a case rate for case management and this will allow the Division to pay providers by the month so people will get the service hours needed. Mike stated that the reality is there is significantly less money with Medicaid and there will be fewer services because $400 million was cut out of the Medicaid budget. Andrea Stevens mentioned that people don't get this fact that there is no money, they just think that people are doing things wrong. Mike Watson expressed his concerns that the services need to go to people who need it the most and that the service is provided in a quality way. Laura Keeney agreed and stated that in a few years there will be an increase in illness and the GA will see there's a need for more services. CABHAs don't have to be certified everywhere and if they get a medical director half time they will meet the criteria to be a CABHA. Plus, substance abuse services can be provided outside the CABHAs. • Kathy Crocker commented on the loss of good paraprofessionals and high school graduates who were taken out of the workforce as a result of staff qualifications and credentialing in place today. She also mentioned that the focus needs to remain on quality of service provision. The discussion included the recent change in the certification process for peer support specialists (PSS) and they no longer need 6 months work experience to be certified as a PSS. • Carl Noyes was concerned with the time frame for CABHAs and the organization needs time to develop a business structure in order to meet due diligence and work with the IRS. Mike briefly touched on timeframes with Medicaid rules around liability and risks. Plus, the CABHA certification process doesn't end July 1, 2010. • Leza mentioned the importance of providers completing the NC TOPPS survey because it is a core compliance issue with providers completing data as required to review and assess information received. Mike said we need to get to best practices and it's imperative that good providers are recognized, not penalized. Several of the SCFAC members were concerned about people losing services across the state, and Mike mentioned his concern about services people receive and do they really need the service because data shows otherwise.	

	• This year, the LMEs contributed fund balance totals of $25 million and the Division is putting data together using last year's audits to determine whether the amount was what LMEs were supposed to put in. Ron Kendrick is extremely concerned with accountability and mentioned the *Total Business Model* and it's not the political will to be committed to accountability. • Mike Watson stated that the goal is to move the state to a 1915 (b)(c) Waiver for MH/DD/SA services. The Waiver allows the state to waive some aspect of the Social Security Act and eliminates the *any willing and eligible provider clause* which allows a LME to limit the provider network. The program operates on a capitated environment and they won't be paid a fee for service but an amount negotiated with the LME per member per month (i.e. PBH currently receives $135 per member per month). The fee is based on two things: 1. Historical usage, and 2. Any change in the Medicaid program. This option allows the LME to control the money and creates incentive to encourage care the way we need it. Presently, 34 states have one type of waiver or another and providers might not like the Waiver because it works toward deinstitutionalization and serves people in the community. The Waiver process will drive consolidation of LMEs and it has already started to move in that direction as there are discussions going on right now between LMEs. Today, there are only six LMEs that meet the criteria to submit the Waiver RFA which is due April 14, 2010. • Judy and David Taylor, Jr. asked the following questions: o What will happen to the CAP waiver that exists now? Mike explained that they will crosswalk services. o Who are the consumers on the Waiver process? John Owen and Anna Cunningham are working on the approval end of the waiver process and they had to sign confidentiality forms. o What will the Waiver do to small providers like Team Daniel? Leza stated that they are a small specialty provider and thinks they will be okay, although there is no guarantee. Leza stated that once the implementation phase begins they will bring in 1-2 consumers for the final process. In addition, the CFACs must approve the LMEs application for the Waiver RFA.	
Discussion with Division Leadership **Leza Wainwright**	• State CFAC members received a letter from Tim Blake, CenterPoint CFAC Chair, regarding Implementation Update #66 concerning the reduction of hours for case management. Leza explained that the GA cut $41 million of the $45 million budget and this created the need to reduce services without completely eliminating services. Therefore, case management will be allowed 3 hours per month. The proposed service definition for the Proposed Clinical	Kathy Crocker will draft a letter to Tim Blake and CenterPoint CFAC acknowledging receipt of their concerns.

	Policy 8A Mental Health/Substance Abuse Targeted Case Management may be reviewed at http://www.ncdhhs.gov/dma/mpproposed/index.htm o The new definition of case management for DD requires a set number of hours for training for the case managers. However, the DD consumers and advocates are advocating for high school grads, but it takes a higher level of education to provide quality case management. • The new Community Support Team (CST) has a limit of 5 hours per week and Leza has concerns that the weekly time might not be good. David Taylor asked if the case management visits were reduced and Leza said not at this time, but the Division will be reviewing this to ensure appropriate visitation. Currently, the State waiver says that all CAP MR/DD case managers need to see the consumers once a month. However, with the 1915 (b)(c) Waiver, an LME can waive state wideness. Unlike PBH, case managers need to be putting in the hours when they go to reviewers to ensure that the appropriate number of hours are being used. • Assertive Community Treatment Team (ACTT) is set up on a case rate of $300 per month and in order to bill for services providers must bill four separate times per year to get the full $1200 and it's done this way to ensure that consumers are receiving services. • Leza reiterated Mike Watson's statement that CMS has already approved State Plan Amendments (SPA) for CABHAs to be the only provider of Community Support Treatment (CST), Day Treatment and Intensive In-home. In addition, Leza acknowledged that due to the elimination of CSS, the Division is presently seeking to get a SPA for 60-90 additional days of the service until other services are in place. • Ron Kendrick inquired about the services for the deaf. Leza mentioned that there is discussion at the State level regarding the possible elimination of deaf residential services and putting the focus on deaf and blind interventions. The cost is astronomical for the residential facilities. • Leza stated that the General Assembly has already been told that they will need to reduce the Medicaid budget by one billion dollars this year. The GA can't touch the Medicaid eligibility requirements because CMS mandates this component. This means that the states can't increase the assets or income and the only thing that can be done is reduce optional services. In addition, since it's an election year there is no talk about raising taxes this year. However, Secretary Cansler has made it very clear that the DHHS can't afford anymore cuts at all. Andrea Stevens requested that the Division solicit advice from SCFAC members on these issues that are being discussed in the GA. • On Monday, March 15, 2010, the Medicaid drug program goes into affect and the preferred drug list must be utilized first before authorizations will be	

	approved for drugs that are not on the list. Paul Russ was concerned that all the drugs on the list appear to be generic drugs and there is a need to try the generic first before an authorization can be received to try a new drug.	
Advocacy Workgroup	• Laura Keeney attended the Advocacy workgroup meeting in Raleigh on February 24, 2010. In addition, the following consumer advocates were present via teleconference or in person: Marc Jacques, Laurie Coker, David Cornwell, Michael Weaver, and Martha Brock. Division staff included Stuart Berde, Wes Rider and Cindy Koempel. The following suggestions were made: o Improve Division website to include more user-friendly documents (i.e. laymen terms, PowerPoints, Newsletter options, periodic update from Leza, etc). o Include SCFAC accomplishments on the SCFAC web page. o Develop a mailing list to advocacy organizations and disseminate information and announcements concerning upcoming meetings. o Participate in the development of service definitions. o Increase diversity of group projects to include youth, consumers, Division/State staff, and providers. • Members from advocacy agencies mentioned the possibility of providing funds to assist with travel expenses in order for consumers to participate. The next meeting is scheduled for March 31, 2010.	
Legislative Oversight Committee (LOC) Update	• Andrea Stevens and Carl Noyes addressed the LOC on March 10, 2010. Andrea expressed her concerns and stated that the SCFAC needs to be an important part of the GA and LOC decision making process. In addition, she said the Division is making good steps in the right direction for consumer inclusion. Andrea acknowledged that the SCFAC believes the 1915 (b)(c) Waivers are the direction to go, but stressed the importance that the process for CABHAs needs to slow down. Ron Kendrick also mentioned the need to slow down and be thorough and pragmatic in the process. • Wilda Brown acknowledged Ron for doing a wonderful job at getting a permanent seat for SCFAC at the LOC meetings, and influencing policy is a role for SCFAC to continue.	
Medicaid Waiver **Ken Marsh and Kelly Crosbie**	• Ken Marsh distributed a draft handout which included an article titled *Medicaid Waiver expansion Planned for 2011* that appeared in the NC Council of Community Programs January 2010 newsletter. Plus, the handout has a chart identifying the *Policy differences between a current LME and a LME Waiver entity*. The following Policy framework was identified: o Capitation/Funding o Payer of claims o Rate setting authority o Closed provider network	

	○ Utilization management ○ Care coordination management • Ken explained that CMS has high expectations and rules and guidelines that must be followed. Every LME that wants to be a Waiver entity must have enough quality providers to provide services for those in need. Rosemary Weaver inquired about the process for terminating an LME that doesn't end up meeting the goals and requirements to be a Waiver entity. Stuart Berde stated that Medicaid has a very strong hearing and appeals process built into the Waiver and LMEs will still have a complaint and grievance process. Ken mentioned that the LMEs will need to go through independent auditor reviews by CMS once they are a Waiver entity. Kelly Crosbie stated that the majority of states are already on a Waiver. Additional information on the Waiver process can be reviewed at http://www.ncdhhs.gov/dma/lme/MHWaiver.htm • Rosemary Weaver provided SCFAC members with the Questions and Answer handout that was developed as a result of the Waiver RFA Bidders Conference held on March 4, 2010 and can be reviewed at the following website http://www.ncdhhs.gov/mhddsas/waiver/1915bcwaiverfinalqa3-10-10.pdf • LMEs interested in applying to be a Waiver entity must submit their RFA by April 14, 2010, and the application must include a letter of support from their local CFAC and the LME Board. Once the LME(s) is selected to be a Waiver entity, then they will need to go before each County Commission and get a letter of support from each county. In addition, the LMEs must have a marketing campaign and a plan for notifying all individuals receiving services of the changes. • Ken asked SCFAC members to consider 1-2 SCFAC members who would be willing to participate on the Waiver Leadership Group, which meets the 1st and 3rd Thursday of each month. Bill Cook stated that the SCFAC members will decide who participates on this workgroup. Andrea Stevens, Services Task Team Chair, and Kathy Crocker, SCFAC/LCFAC Interface Task Team Chair, agreed to discuss this with their respective task team members during the work group session today.	
Peer Support Specialists (PSS) Rosemary Weaver and Gladys Christian	• Rosemary and Gladys developed a PSS presentation for SCFAC members that included: ○ The Role of PSS. ○ Behavioral Healthcare resource Program (BHRP) has posted a map consisting of the Certified PSS in NC, and as of today there are 136 certified PSS. ○ PSS certification requirements. ○ An overview of the approved curriculum process in NC. ○ How can PSS be utilized in NC? ○ Benefits of employment as PSS.	

	○ Challenges for peers in the work place. ○ Rosemary provided some personal experience of her own as a PSS. • For additional information on NC's PSS program, you can review the website http://pss-sowo.unc.edu/index.php?q=psshome	
Next Meeting Date	• The next meeting is scheduled for May 13, 2010 from 9:30 A.M.-3:00 P.M. The meeting will be held in the Four Sisters Room at the Clarion Hotel State Capital, 320 Hillsborough Street, Raleigh, N.C.	
May 2010 Meeting Agenda	• Approval of the Agenda. • Approval of the March 2010 minutes. • Public Comments/Issues. • SCFAC Elections. • Discussion with Division Leadership. • Medicaid Waiver Update with Ken Marsh. • Invitation to the NC Developmental Disabilities Council. • Task Team Work session.	